The AHCCCS Director Responds

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I agree, as Dr Jane Orient states in her article ("Arizona Health Care Cost Containment System—A Prepayment Model for a National Health Service?"), that the outcome of the AHCCCS demonstration is important for physicians, taxpayers and patients. This was the main reason I became director of AHCCCS in April 1984. At that time AHCCCS faced severe administrative difficulties. Since AHCCCS began operation on October 1, 1982, it had experienced a number of problems, many of which could be traced to a lack of adequate time for planning, the experimental nature of the AHCCCS concept and the lack of available expertise in prepaid medicine.

AHCCCS is the nation's first statewide program to provide medical service on the prepaid concept as opposed to conventional fee-for-service in other Medicaid states. AHCCCS is a demonstration project aimed at testing the use of prepaid, capitated financing of health care services for indigents and other eligible state residents.

Dr Orient raises four interesting questions in her article:

- Should AHCCCS be continued?
- Is the gatekeeper concept sound?
- Does prepayment make medical care more economical?
- Have standards of care been maintained?

These questions are valid and should be addressed. AHCCCS was designed to provide health care and to evaluate these questions. Scholarly research, based upon current, accurate and adequate information, can be exciting and provide an educational opportunity for all interested parties. Such research should communicate facts and further the understanding of AHCCCS.

Unfortunately, Dr Orient's article perpetuates misunderstanding of AHCCCS. If you want a careful, scientific and deliberate analysis of AHCCCS based on fact, her article will be of little value. Dr Orient's questions have merit, and they should have responsible answers.

Is the Gatekeeper Concept Sound?

I would like to take this opportunity to respond to what Dr Orient perceives as the answer to her questions. To provide perspective I will address the question regarding the future of AHCCCS last and the gatekeeper question—"Is the gatekeeper concept sound?"—first. Dr Orient dismisses the gatekeeper as a sound medical concept. Dr Orient's argument against this concept is based on the assumption that all AHCCCS gatekeepers or primary care physicians (PCPs) are capitated and, therefore, they are all at risk. Among AHCCCS health plans, some PCPs are capitated. Capitation is not the only contract form between PCPs and health plans. For instance, the two main county health plans (Maricopa and Pima) and the University of Arizona's health plan are staff models. Two of the largest health plans (Arizona Physicians-IPA and Access Patients Choice, Inc) have modified fee-for-service and capitation agreements. Therefore, the assumption that all AHCCCS PCPs are at risk is incorrect.

Should a health plan fail, a capitated PCP may be at risk. However, AHCCCS has developed a bonding structure to reduce this risk. Health plans are now required to either secure an irrevocable letter of credit, execute a performance bond of standard commercial scope or provide a cash deposit to AHCCCS. In the event of a default by the health plan, AHCCCS will execute on the bond for the purpose of mitigating any damages incurred by providers.

Dr Orient presents an example of the potential financial and legal jeopardy of PCPs. This example is the indemnification and insurance clause from a health plan's subcontract. This clause does place the PCP at financial and legal risks as a result of the PCP's negligence or omission. This clause does limit the responsibility of the state in case the contracting health plan fails to reimburse the PCP subcontractor. In instances of dispute regarding payment for services, the health plan maintains a system for grievances. The health plan is required to provide a responsive system to resolve grievances and this system is available to the PCP. Thus, the PCP has a process for relief should there be a payment dispute.

In citing the evidence from the United Healthcare Corporation (IPA) experience, Dr Orient makes a mistake common to those unfamiliar with the prepaid concept. According to the article referenced by Dr Orient, United Healthcare used a fee-for-service reimbursement system. Furthermore, the referenced article concluded that the adequate incentives were not applied for the PCP to control the use of services. In fact the article references the working of a group account system. This is in no way similar to the AHCCCS model.

Paraphrasing a conclusion in an article in the December 1983 *New England Journal of Medicine (NEJM)* on the SAFECO experience, Dr Orient says, "So far, AHCCCS has not contradicted evidence from the United Healthcare Corporation IPA that primary care coordination by a gatekeeper is

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ABBREVIATIONS USED IN TEXT

AAAHC = Accreditation Association for Ambulatory Health Care
AHCCCS = Arizona Health Care Cost Containment System
PCP = primary care physician

not sufficient to contain health care costs." That's not exactly what the authors of the *NEJM* article concluded, although it is a portion of one of their conclusions.

"In our view, the SAFECO experience shows that primary-care coordination *by itself* [emphasis added] is not sufficient to control health care costs," the authors of the *NEJM* article said. Dr Orient misinterpreted a statement from a referenced article and tried to prove that AHCCCS does not work. I agree with most of the conclusions in the *NEJM* article and would point out that AHCCCS has enacted many of the recommendations cited in the article.

According to Dr Orient

> the patient's welfare is no longer his or her [the gatekeeper's] preeminent concern. The gatekeeper's incentive to provide "cost effective" treatment is to maximize reimbursement. To prevent "overutilization," the gatekeeper must be placed "at risk," thereby placing patients at risk also, even if unintentionally.

Dr Orient's inferences that physician motives are based upon profit rather than ethical health care considerations are offensive to me as a physician and to the medical community. If Dr Orient has any evidence of a physician placing a patient's welfare at risk, either intentionally or unintentionally, she has a duty as a private citizen and public servant to present it to me and the appropriate medical regulatory boards.

Dr Orient presents no evidence to support the claim that PCPs are required to deny needed care and assume an adversarial role with the patient. AHCCCS has a comprehensive utilization review system designed to ensure that AHCCCS members receive the medical care they need.

Does Prepayment Make Medical Care More Economical?

"Does prepayment make medical care more economical?" is an interesting question and one that must be answered. The charge that "cost containment" means reducing services or shifting costs is unsupported. The AHCCCS program has a system to verify a person's eligibility for services and that system is responsive to the PCP. The time and effort required to verify enrollment has been reduced continually. To protect the PCP from uncompensated care, many health plans have prior authorization systems. Should a PCP fail to verify a patient's enrollment or obtain prior authorization, then that PCP may be at some risk.

Furthermore, Dr Orient suggests that, "The most obvious method of cost-shifting is to deny or delay reimbursement to providers." As evidence of "cost shifting," Dr Orient cites a lawsuit filed against the state by hospitals, physicians and others. That suit was filed by providers who had claims against one health plan at the time it filed a bankruptcy petition. That is hardly an example of willful cost shifting. Furthermore, bonding provisions would now protect against this.

The cost shifting examples are insufficient to answer the question posed by Dr Orient. The facts, as presented by Dr Orient, do not support her conclusions.

Has the Use of Private Providers Improved Access?

The access to care question ("Has the use of private providers improved access to care?") is one in which I have professional interest. Dr Orient states that "persons eligible for AHCCCS did report gains in access to health care" but totally ignored this fact in presenting the conclusions.

I must stress that AHCCCS is designed to serve those who are eligible. The important fact is that there is empirical evidence that AHCCCS has improved access to care for those people eligible. Dr Orient's confusion regarding eligibility requirements and access to care is puzzling. Because AHCCCS has eligibility provisions is not justification to dismiss the program.

Dr Orient also contends that about 21,000 patients "were forced to dissolve doctor-patient relationships at the county facility, Maricopa Medical Center, when the county's bid was rejected by AHCCCS. . . ." It is true that the Maricopa Health Plan lost a portion of its contract in 1983 and 15,000, not 21,000, members had to select another health plan during the annual open enrollment process that is available to all AHCCCS members. The remaining 6,000 members who left Maricopa were not forced to switch health plans but did so voluntarily during the open enrollment process.

Dr Orient further contends that 35,000 patients statewide "changed gatekeepers on a single day." That occurred in 1983, during the program's first open enrollment process and at the end of the first year of operation. The reason the figure was high was twofold: (1) The figure included the 15,000 members that Maricopa Health Plan lost and (2) About 20,000 members chose to switch health plans voluntarily. The latter number was high but not surprisingly so considering 1983 was the first year of operation. Moreover, switching health plans is what open enrollment is all about—freedom of choice, which is what Dr Orient claims is missing in this program.

AHCCCS has had two open enrollment periods since the one in 1983. About 14,800 members changed plans in 1984 and 9,994 (or roughly 6% of our total membership) changed plans in 1985.

Have Standards of Care Been Maintained?

In addressing the question concerning standards of care ("Have standards of care been maintained?"), Dr Orient charges that AHCCCS has done little to implement a consistent mechanism for "quality assurance." AHCCCS has a quality assurance program that is designed to ensure that the delivery of cost-effective medical care does not compromise quality. This program is designed to assure that beneficiaries are provided care that equals or exceeds the quality of services provided to the general fee-for-service public. Each health plan is required to have a formal quality assurance review plan that continuously monitors quality of care.

The AHCCCS Medical Director, Albert W. Bostrom, MD, reviews the adequacy of the design and implementation of the quality assurance review plans. He works with each health plan's medical director to ensure that the quality assurance review plan is professional and functional.

AHCCCS actively monitors this critical component. Each year the AHCCCS program conducts an independent medical audit of the health plans. The audit that Dr Orient referred to

in her article was conducted by the Accreditation Association for Ambulatory Health Care (AAAHC) under contract to AHCCCS. Of the audit, AAAHC said, "It remains, to our knowledge, the most thorough review of any Medicaid program in the United States." Dr Orient failed to note the actions taken by AHCCCS as a result of the audit. AHCCCS assisted each health plan in addressing identified problems. There was considerable follow-up in every case.

Dr Orient states that preliminary statistics for 1983 show the number of births with no prenatal care had increased 12.7% compared with 1982. She then states, "Because of the preliminary nature of the data, it would be premature to draw definite conclusions about the impact of AHCCCS." If that is true, why mention it? If the author had been informed on this issue, she would know that other areas of the country are experiencing similar problems. The problems are not unique to Arizona and they are not just medical, but financial, social and cultural. Futhermore, the statistics are presented by Dr Orient without the explanation that they cover the state's entire population, including insured and self-pay people.

Should AHCCCS Be Continued?

Now to the final question: "Should AHCCCS be continued?" Dr Orient stated that "At present the high cost of AHCCCS, combined with the undetermined quality of care and possibly diminished access to care, would appear to me to favor dismantling the program and returning to the old county system, perhaps with deficits funded by the state if necessary." This statement is both contradictory and confusing.

To those unfamiliar with the history of indigent health care in Arizona, it would appear that Dr Orient makes a valid case regarding expenditures for indigent healthcare. The counties had been responsible for indigent health care in Arizona since before statehood in 1912. In 1974 the Arizona Legislature passed a bill authorizing the state to join the federal Medicaid program. However, the legislature did not appropriate any funds and the counties remained responsible for indigent health care. In 1981 the legislature responded to growing fiscal concerns from the counties and created AHCCCS.

Differences between the county system and AHCCCS are pronounced. There were separate and distinct eligibility requirements and processes for each county. Levels of services varied by county; what was a covered service in one county was disallowed in another. This system of health care for indigents was confusing and forced many indigents to accept a lower standard of health care.

AHCCCS has uniform standards for state-supported indigent care and a minimum health care service package. AHCCCS standardized the eligibility requirements and process.

AHCCCS replaces traditional Medicaid fee-for-service with a prepaid health care delivery network. AHCCCS provides quality mainstream health care to eligible people, contains costs and provides a stabilized annual base from which the state, county and federal governments can predict the amount of funding that will be necessary for the required services.

Dr Orient attempts to discount AHCCCS because of an alleged increase in the counties' expenditures for indigent care. Dr Orient, to prove the increase in cost, compares the cost of the ad hoc county system with the cost of AHCCCS with no attempt to adjust for differences between the programs. This process lacks the rigors of quantification and produces misleading results.

Dr Orient may disagree with the AHCCCS concept but she has a professional responsibility not to allow personal objectives and values to bias the analysis. The use of undocumented personal communication is an example of an inadequate understanding of the accepted research methods.

Analyzing the cost of AHCCCS is difficult. It is impossible, given space limitations to present the data necessary for such an analysis. The Health Care Financing Administration has entered into a contract with the Stanford Research Institute for this analysis.

Dr Orient's position regarding the alleged increase in cost is untenable. The evidence to support her claim is misleading. There was no analysis of how the $63 million the counties contribute to AHCCCS was computed. By state law, the counties contribute to AHCCCS one half of what was budgeted or spent on indigent care in 1980-1981, whichever was less. This amount was adjusted to compensate for service provision differences between the county-based program and AHCCCS. The $63 million amount is stable. Counties are not required to contribute any other amounts, even though enrollment may increase. The number of people served by AHCCCS is substantially greater than the number served under the "old" county system. It is unfortunate that Dr Orient attempted to ignore this fact.

It may be inviting to include the amounts from the state and federal governments, but it is improper. The state is capitated by the federal government for those people who receive Aid to Families with Dependent Children or Supplemental Security Income benefits. The health care costs for the state-eligible group—Medically Indigent/Medically Needy (MI/MN)—are borne by the state. These are in effect new dollars and are intended to be used to serve groups of people, some of whom may not have been served by the old county system in 1980-1981. The mixing of "notch group" cost with AHCCCS cost is misleading. The question of providing services to the "notch group" is serious. However, AHCCCS was intended to provide health care to those who are eligible. This is why the county contribution is set at one half of the counties' 1980-1981 health care budget or actual expenditures.

The addition of the counties' cost for long-term care to the AHCCCS cost is improper. These are "room and board" costs and by state law are the responsibility of the counties. AHCCCS has contracts to provide for the medical costs of those eligible persons residing in long-term care facilities.

Like a child in a candy store, Dr Orient went through a legislative report prepared by Marie Romano, selectively quoting figures that tended to support Dr Orient's contentions on AHCCCS costs versus costs under the old county health care delivery system. While Dr Orient correctly quoted an $11 million savings cited by the report, she ignored a number of other statistics presented in the report that would not support her conclusions.

As an example, the $11 million savings was the difference between what it would cost the counties if they provided AHCCCS covered services to AHCCCS eligible people ($328,230,294), minus what was spent on all indigent health care statewide in fiscal 1983-1984 ($317,165,961). However, according to the report, for the counties to provide those

services to those people, the counties would have to increase their budgets by $164,346,533.

The report contains other costs comparisons for fiscal 1983-1984 and fiscal 1984-1985, based on service and eligibility levels. Those figures indicate even greater savings to the counties.

Dr Orient is fully prepared to dismiss AHCCCS based on quality of care and access to care issues. However, in both cases Dr Orient is categorically mistaken. AHCCCS does have an excellent program to evaluate quality of care and a corrective action plan to educate PCPs when substandard patterns are found.

Dr Orient submits that AHCCCS has improved access to care for those eligible. It may be comfortable to blame AHCCCS for access to care problems of the "notch group," but it is incorrect. AHCCCS is responsible to provide care to those people who are eligible—and AHCCCS has fulfilled this responsibility. I agree that providing health services to the notch group is important, but to dismiss AHCCCS on this issue is unfounded and inappropriate.

In summary, it is evident that Dr Orient has failed to provide current, accurate and adequate information concerning AHCCCS. I respect and applaud scholarly research based on empirical evidence. When scholarly research is pushed aside for value judgments, then the entire medical profession suffers.